THE HEALTH SERVICES DELIVERY SYSTEM*

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I SHALL attempt to bring to life some of the things I have experienced during the past few years. I shall not talk about what we intend to do regarding health care nor shall I emphasize how disappointing it is that our country has not lived up to its obligation to provide health care for its citizenry. I intend to talk about existing conditions and why they exist.

I shall discuss the Howard University Mississippi Project, nicknamed HUMP. It is one of the projects with which I have worked since its inception. This story is not very pretty. I believe that the story of the delivery of health care in this country is very ugly.

In 1969, while I was a student at Howard University College of Medicine, Washington, D.C., some of my peers and I were sitting in what one might call a neighborhood bar trying to decide whether we should study for the night (after three or four years as a medical student one makes those decisions). We were approached by a local representative of the Southern Christian Leadership Conference who said, "You guys are always *talking* about health and, most unfortunately, you are the physicians of tomorrow." He went on to say, "Let me show you a situation where you can *do* something. If you really want to involve yourselves with health, see what you can do with this particular situation." He then began to describe to us what later proved to be a living hell.

Young, eager, and full of vigor, we accepted the challenge and traveled to a small place called Quitman County, Miss. For the past two years Quitman County has been my favorite subject. It is in the north-central section of Mississippi, approximately 64 miles south of

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Memphis, Tenn. It borders on the Cold Water River and is in the heart of the Delta.

The minute one begins to talk about Mississippi, more than enough persons say, "Well, you know, you are talking about another country." But Mississippi is not really another country. It exists right here in the United States. I cannot tell you all the things we found in Mississippi; I cannot tell you all the things that have happened to us because of what we found; nor can I tell you all the things we have done and plan to do in the future. I shall try to concentrate on a few items.

After a series of visits, examinations, surveys, and other involvements, we contracted with the Delta Hills Head Start Program to examine 1,060 children from a five-county area in north Mississippi who were enrolled in the Head Start Program. We found conditions in that section of the country that were well known to some well-informed persons. This was not exactly an 1849 gold discovery. We found that among these preschool children 82% were triply infected with important parasites. If you can understand the schisms of black people and how paranoid we are, you can understand that our children are the only asset we have; they are our lifeline. Eighty-two per cent had serious parasitic infestations. These children were supposed to be the "best off," and they are, because they are enrolled in the Head Start Program. They are learning hygiene. What chance do the other children have?

We found that more than 62% of the children did not have toothbrushes; we found among approximately 500 families interviewed that of those individuals over 40 years old, 65% had never seen a dentist; we found a county with a population of 20,000 people that ranked number 37 in density of a total of 82 counties in the State of Mississippi; we found that the county had no hospitals whatsoever for blacks or whites.

Quitman County had seven physicians: four of them practicing full time. There were three dentists (now there are only two), two pharmacists, and 26 nurses (registered nurses, practical nurses, and midwives). None of these were black, yet the county had a population of 63% blacks.

These conditions have been known to many persons for many years, but they just have not appeared to cause concern. The general

condition was much like that of Appalachia. It took the Student American Medical Association (SAMA) to bring this situation to the attention of the American public. Health conditions that exist for minorities are very well known. Minorities are the most studied people in the United States. When one talks about the health of the American Indian, the Puerto Rican, the Spanish-American, the Chicano, and the black American, the facts and statistics are available. To prove that, we took our values and statistics and compared them with the Allied Health statistics compiled by the director of Allied Health in the State of Mississippi; we compared them with those of the Office of Economic Opportunity (OEO); and we found the statistics in both cases superimposable.

Bobby James, coordinator for Adult Education Programs in Quitman County, testified before the American Medical Association Committee on Health Care for the Poor (on which I served as a member). He said, "The situation in Quitman County is such that blacks cannot receive health care after 5:00 p.m." His testimony is a matter of record.

I cannot overemphasize the fact that this country is well aware of the conditions of minority health care delivery. The president of the United States recently proposed the allocation of five million dollars to study a genetic defect of blacks. I have attended many meetings and listened to too much dialogue pertaining to federal health insurance, overutilization, etc., but the confusion that exists concerning health care delivery systems is going to continue to exist until we understand the problem.

When one talks about health decay in this country, one is really talking about health brutality: East Harlem, a section of New York City, has not even one physician—and the people ask why they cannot get one. One must understand that this is a minority section, like the West Side of Chicago; like the area served by the District of Columbia General Hospital in Washington, D.C.; like that served by the Boston General Hospital (which serves patients who do not have a general physician). Then there is the health decay that Dr. Paul Cornely discovered last year when he toured the United States and walked through the ghettos. He found that on the North Side of Chicago there was one building that contained more physicians than the entire South Side—that one building served a population of well over 800,000 persons.

One must remember that in talking about health one is not talking about medical care. Funds can be legislated, laws can be legislated, but the attitudes of some physicians cannot be changed so that they will want to go where there is a health need. When one talks about health care delivery systems, Howard University has converted many of its students (including myself and others) by saying, "You have presented a problem situation—now do something about it!"

We have developed a health care system (consistent with the definition of health prescribed by the World Health Organization). We are talking about *total life styles of individuals.* We are not talking about "how to make a patient well" in our offices or hospitals; we are talking about his housing, his welfare, his total life style. We found that 43% of the houses in Quitman County did not have sanitation facilities. We found that the total amount of welfare money amounted to less than $3,000 in a county that ranked in the lower 99% of all counties in the United States.

When one examines some of the bills that are in Congress that are based on the ability of individuals to purchase health insurance one finds that residents of low-income areas are being left out again because they cannot afford to purchase health insurance. We did a survey on the types of insurance companies existing for these residents, and found that there were 14 of them—the largest one doing business in Quitman County was the Metropolitan Life Insurance Company—not Blue Cross, not Blue Shield, nor Aetna Casualty Life.

We found that there were no hospitals, no health facilities, no transportation, no sanitation. We cannot chew the worms, we cannot talk about a system of delivery for health care.

So we believe that in talking about health care, the young physician (when I say young, I mean young in attitude, not age) who is willing to pay a price must become a social force today. That social force could be a politician or it could be a doctor. Many physicians are what we call "be" doctors, but very few of them are "do" doctors (that statement comes from a famous friend of mine, the Rev. Jesse Jackson). The difference between "do" doctors and "be" doctors is that once individuals become physicians many doctors stop. A famous doctor in Beaufort, S.C., said before an American Medical Association (AMA) committee: "My God, I was practicing down there every day from eight to eight; my office was full every day—six days a week." And he

said, "I thought I was providing health services until I looked up one day and all of a sudden somebody from OEO started talking about a Neighborhood Health Center and the community asked me to be on the Advisory Board."

I went before the Advisory Board, and the community picked me apart! These same people were my patients. I did not understand until I was told that I was providing what was called medical care, but not health. I was not participating in what the community was all about. Physicians' attitudes have not changed. The force that has encouraged physicians to start policing other physicians who are not doing their job has been the community. One can say that the cost of malpractice has jumped three times in one single year, and that is not improved care. Physicians have begun to look around and say, "Look, buddy, you are causing me to be sued." I think that if malpractice had not come about, many physicians would still permit their colleagues to do whatever they wanted.

We have committed 11 schools of Howard University to the Howard University Mississippi Project—and all of the disciplines are focusing on one subject: HUMP. In trying to institute a project which we consider total health care (not just medical care), we have encountered many "humps": we were told that there was no need for our assistance—the "people down there" did not need health care. We have letters in our files written to officials by John Bell Williams, Senators John Stennis and James O. Eastland, Representative Jamie Whitten, and others saying of us: "They don't need to be there; they are going to cause trouble; there is nothing wrong with the people in Quitman County."

There is a five-county area surrounding Quitman County. Tunica County borders the north side of Quitman County and has a doctor/patient ratio of one to 4,250; Cohoma County (which has the only hospital in the five-county area) has a doctor/patient ratio of one to 1,650, the best ratio in that area. But it is claimed that the people do not need physicians there.

We have applied to government agencies for funding, and we have been told: "The situation is too hot to handle. We just cannot have an all-black university going down into an area like that, because it will cause trouble." Well, health is trouble.

I was told by the AMA (when it barred me from speaking at the

Rural Health Conference in March 1971 because of these same comments that I made before the Council on Medical Services in Boston) that I am overly involved with the problems of Mississippi and that my feelings toward Mississippi are out of proportion to what they could be to other places in the country.

I do not know how I am supposed to feel when I learn that Mississippi ranks last in the nation in many respects. I do not know how I am supposed to feel when I learn that in the 12-county area of Mississippi welfare, housing, nutrition, health, etc., are three times worse than they are in the rest of the state of Mississippi and two times worse than the national average. Yet I am told that my feelings are out of proportion.

I was born in Chicago, and I do not intend to let Chicago off the hook. Last year we had 599 medical graduates in Chicago—a city that is approximately one third black. If there was one black graduate, then he was graduated from the Medical School of Northwestern University.

If I have a purpose it is to tell you that the physicians who are involving themselves through SAMA and the Student National Medical Association are being exposed to an area whose health conditions are somehow being hidden from us by the universities and the medical schools. We formerly did not have the outreach programs that we have now; the university was not involving itself in other areas of the country; the universities were not really involving themselves in disaster areas and actually living up to the obligations they have. We have those developments now. I hope it is because the physician is going to become the kind of physician that we as a group have always wanted him to be.

In this day and age we do not care so much about organ transplants when we find that people in some sections of the country do not know how to move the privy from the well; we have not got that far yet in Mississippi. And it is not only in Mississippi—there are health pockets of decay throughout this country. Such pockets exist all the way from Boston to Mississippi and from Mississippi to Los Angeles.

In conclusion I quote the words of Dr. James Kinsley, executive director of the American Public Health Association, who said, "Medicine is a science and an art that is particularly supportive of a larger social concept called health." I think that is one of the concepts by which we should live.